State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 17, 2005

Exercise Evaluation Forms

(Note: These Evaluation Forms have been extracted from the full Exercise Guidebook, which is available at www.emsa.ca.gov)

State of California
Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 17, 2005

HOSPITAL FACILITY EXERCISE EVALUATION FORM

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Hospital/Healthcare Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your facility is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Circle the <u>single best answer</u> that describes your facility.

A. Acute care hospital with a basic or comprehensive emergency dept.
B. Acute care hospital with a stand-by emergency department
C. Acute care hospital with no emergency department
D. Specialty care hospital (i.e., trauma, pediatric, etc.)
E. Other

Circle the <u>single best answer</u> that describes the number of beds at your facility.

A. 0 – 99 beds
B. 100 – 299 beds
C. 300 – 499 beds
D. > 500 beds

HOSPITAL FACILITY EXERCISE EVALUATION FORM (continued)

Please indicate the level of participation of your facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate your Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

(For the next series of questions, circle the percentage most representative of your answer):

Objective I: To what extent did your facility participate with other area hospitals, public or private EMS providers, law enforcement, and/or emergency managers to facilitate a community-wide emergency management response?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent is your staff familiar with your Emergency Management Plan and effectively utilized a recognized incident command system or HEICS during the exercise?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did the appropriate staff accurately assess your facility's status and was able to communicate that status, using hospital communication systems (if applicable) to the Operational Area EOC or DOC?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was your facility appropriately prepared to respond to a terrorist-related IED event, including the safety of staff and patients and building security?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was your facility able to establish, and effectively use, alternative communication systems to contact internal and external parties, including local government and partner facilities?

0% 20% 40% 60% 80% 100% N/A

HOSPITAL FACILITY EXERCISE EVALUATION FORM (continued)

Objective VI: To what extent did your facility effectively manage a large influx of patients by clearing beds and activating alternate care sites?

0% 20% 40% 60% 80% 100% N/A

Objective VII: To what extent were scarce resources (blood products, durable medical equipment, staff, etc.) obtained and/or allocated according to established protocols?

0% 20% 40% 60% 80% 100% N/A

Objective VIII: To what extent were risk communication messages, coordinated with local authorities, developed and disseminated to internal and external customers in a timely manner?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your facility's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

In general, to what extent were you satisfied with the November 17 statewide exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations?

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HOSPITAL TRANSFUSION SERVICE EVALUATION FORM

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Blood Bank Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your facility is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the <u>single best answer</u> that describes your facility.

A. Acute Care Hospital with Transfusion Service and Blood Donor Facility.
B. Acute Care Hospital with Transfusion Service.
C. Hospital with general laboratory.

Please indicate the level of participation of your facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate your Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

HOSPITAL TRANSFUSION SERVICE EVALUATION FORM (continued)

(For the next series of questions, circle the percentage most representative of your answer)

Objective I: To what extent did your transfusion service activate a transfusion service-specific emergency plan?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent did your transfusion service accurately assess blood product inventory and was able to communicate that information to the Operational Area EOC via HEICS? And to your blood supplier?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did your transfusion service establish protocols for communicating with appropriate ED staff to determine the expected number of patients and timelines of corresponding blood product requirements?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was your transfusion service able to establish an alternative communication system in order to request blood products from your primary supplier? (please note in the comment section, the type of alternative communication implemented, if applicable)

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent did your transfusion service appropriately manage incoming/outgoing inventory, and conduct compatibility testing using qualified technologists?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was communication with "sister" hospitals established to identify inventory status, timelines and methods of transporting blood products?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your facility's response to the event and initiation of the Emergency Management Plan as it relates to your transfusion service?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified

HOSPITAL TRANSFUSION SERVICE EVALUATION FORM (continued)

D. Needs improvement: substantial Emergency Management Plan review/changes identified.

In general, to what extent were you satisfied with the November 17 statewide exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations?

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CLINIC EXERCISE EVALUATION FORM
(Community Health Centers, Urgent Care Facilities and Indian Health Centers)

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Clinic Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your facility is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI

Please circle the <u>single best answer</u> that describes your facility.

B. Community Health Center
C. Urgent Care Facility
D. Indian Health Center
E. Other: _____

Please indicate the level of participation of your facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate your Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

CLINIC EXERCISE EVALUATION FORM (continued)

(For the next series of questions, circle the percentage most representative of your answer)

Objective I: To what extent was your staff familiar with your Emergency Management Plan?

0% 20% 40% 60% 80% 100% N/A

Objective I: To what extent is your staff familiar with or use the Incident Command System (ICS)?

0% 20% 40% 60% 80% 100% N/A

Objective I: To what extent was your facility's response to the event and initiation of your Emergency Management Plan successful?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent were you able to successfully assess the status of your facility and communicate that status to the Operational Area EOC or DOC?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did your staff correctly evaluate the nature of the situation and take appropriate and immediate action?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was your facility prepared to manage a large influx of patients?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did your facility have an adequate MOU with local hospitals to accept non-acute care hospital transfers into the facility?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did your facility cancel/reschedule patient appointments and/or activated callback procedures to prepare for the acceptance of non-acute care hospital transfers into the facility?

CLINIC EXERCISE EVALUATION FORM (continued)

Objective IV: To what extent was your facility successful in establishing communication with the appropriate hospital(s)?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was your facility prepared to manage a large influx of patients?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent did your facility effectively implement an alternate communication system (other than public telephone service) to reach the local Public Health Department Operations Center (DOC), County Emergency Operations Center, nearby hospitals and/or "sister" clinics?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your facility's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

In general, to what extent were you satisfied with the November 17 statewide exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations?

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AMBULANCE PROVIDER EVALUATION FORM

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Ambulance Provider Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your facility is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the <u>single best answer</u> that describes your service.

A. Basic Life Support
B. Advanced Life Support
C. Both A and B
D. Nurse Critical Care Transport
E. Respiratory Therapist
F. Bariatric Transport
G. Other (specify) _____

Circle the <u>single best answer</u> that describes your service.

A. Private business
B. Fire service affiliate
C. Special district or local government (other than fire service)
D. Hospital affiliate
E. Other (specify) _____

AMBULANCE PROVIDER EVALUATION FORM (continued)

Check the level of participation of your service during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

(For the next series of questions, circle the percentage most representative of your answer)

Objective I: To what extent were ambulance personnel familiar with, and followed your Emergency Management Plan and ICS?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was your ambulance dispatch service kept apprised of ambulance status, and able to communicate that status to appropriate local government entities?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did your ambulance service adequately respond to the increased call volume while hospitals were on diversion due to ED overcrowding?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your service's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

In general, to what extent were you satisfied with the November 17 Statewide exercise?

0% 20% 40% 60% 80% 100% N/A

AMBULANCE PROVIDER EVALUATION FORM (continued)

Additional Comments and Recommendations?

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AUXILIARY COMMUNICATIONS EVALUATION FORM

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Amateur Radio Organization Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your facility is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the <u>single best answer</u> that describes your service.

A. Amateur Radio Volunteer
B. CARES
C. RACES
D. Other (specify) _____

Did you activate your Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't know

<u>Objective I:</u> (Pre-Exercise) Radio operators were familiar with auxiliary communication protocols, frequencies, available backup frequencies and relevant forms?

AUXILIARY COMMUNICATIONS EVALUATION FORM (continued)

(For the next series of questions, circle the percentage most representative of your answer)

Objective II: To what extent were radio operators able to setup operational alternative/redundant systems, access appropriate frequencies and complete relevant forms?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent were messages and data transfer transmitted and received between local, operational area and region as required by exercise specifics?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent were frequencies available for transmission during the exercise?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your service's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

In general, to what extent were you satisfied with the November 17 Statewide exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations?

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OPERATIONAL AREA EXERCISE EVALUATION FORM

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA) by December 9, 2005. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Operational Area: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region your Op Area is located (Listed on *PAGE* 65)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Circle the level of participation of your OA EOC during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate your Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

Did you activate the Medical and Health Branch of the EOC?

A. Yes
B. No
C. Don't Know

OPERATIONAL AREA EXERCISE EVALUATION FORM (continued)

Did you activate other branches in the OA EOC during the exercise?

A. Yes
B. No

(For the next series of questions, circle the percentage most representative of your answer)

Objective I: To what extent were hospital status and resource needs accurate, appropriate and timely; and to what extent were updates provided to the region?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was the MHOAC function activated and ongoing communication to the medical/health branch and RDMHS regarding resource status maintained?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was Operational Area EOC staff proficient in utilizing information via the RIMS medical/health report as appropriate?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent were Amateur Radio Operators available and utilized for two-way messaging?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent were risk communications messages developed and transmitted in coordination with CDHS?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate your department's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

OPERATIONAL AREA EXERCISE EVALUATION FORM (continued)

In general, to what extent were you satisfied with the November 17 Statewide exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations?

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